Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 002703 | A. BUILDING: _____ B. WING _____ | C 05/10/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMEWOOD HEALTH CAMPUS | 2494 N LEBANON ST LEBANON, IN 46052 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00193930 and IN00198456.<br><br>Complaint IN00193930 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00198456 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: May 06, 09 & 10, 2016<br><br>Residential census: 37<br><br>Sample: 13<br><br>Homewood Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00193930 and IN00198456. | R 000 | | |

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE